City of Long Beach

EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

If you are declining enrollment for yourself because you have other health coverage, you may in the future be able to enroll yourself in a health plan, provided that you request enrollment **within 30 days** after your other coverage involuntarily ends.

If you are declining coverage, please check one of the following reasons:

I decline coverage for:
☐ Myself

Declining coverage due to existence of other coverage: **(Attach Copy of Your Proof)**
☐ Spouse's Employer's Plan
☐ Individual Plan
☐ Covered by Medicare
☐ Medicaid
☐ COBRA from Prior Employer
☐ VA Eligibility
☐ I have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have been given the opportunity to enroll in an employer medical plan.

Date: _____

Signature: _____

Printed Name: _____